

# Unearthing the Buried City

## *The Janet Translation Project*

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This document is part of *Unearthing the Buried City: The Janet Translation Project*, a series of AI-assisted English translations of Pierre Janet's works.

In his seminal 1970 book: *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry*, Henri Ellenberger wrote:

*Thus, Janet's work can be compared to a vast city buried beneath ashes, like Pompeii. The fate of any buried city is uncertain. It may remain buried forever. It may remain concealed while being plundered by marauders. But it may also perhaps be unearthed some day and brought back to life (p. 409).*

This project takes Ellenberger's metaphor seriously — and literally. The goal of this work is to unearth the buried city of Janet's writings and make them accessible to the English-speaking world, where much of his legacy remains obscured or misunderstood.

Pierre Janet was a pioneer of dynamic psychology, psychopathology, hypnosis, and dissociation. His influence on Freud, Jung, and the broader psychotherapeutic tradition is profound, yet the bulk of his original writings remain untranslated or scattered in partial form. These AI-assisted translations aim to fill that gap — provisionally — by making Janet's works readable and searchable in English for the first time.

This is not an academic translation, nor does it claim to replace one. It is a faithful, literal rendering produced with the aid of AI language tools such as Chat GPT and DeepL and lightly edited for clarity. Its purpose is preservation, accessibility, and revival. By bringing these texts to light, I hope to:

- Preserve Janet's contributions in a readable English form
- Spark renewed interest among scholars, clinicians, and students
- Inspire human translators to produce definitive, academically rigorous editions

# A Case of Hysterical Hemianopsia<sup>1</sup>

*Lecture given at the Salpêtrière on January 25, 1895*

By Dr. Pierre Janet

Gentlemen,

Professor Raymond has kindly allowed me to continue, under his service, the psychological research I had undertaken for several years under the direction of our excellent and much-lamented master, Charcot. I am deeply grateful to him; I hope that my work will provide some useful documents for his lessons and that, in a very small way, they may assist him—like the research of his other students—in his efforts to preserve and increase the long-standing reputation of the clinic.

My master, Mr. Raymond, has asked me today to present to you a pathological case that is rather curious due to the problems and discussions it has provoked. This case is quite closely related to my earlier studies on hysterical anesthesia, some of which I presented here three years ago. It is a case of hemianopsia, a more or less complete suppression of one half of the visual field, and this symptom—without affirming too categorically—seems to me, for a number of reasons that you will appreciate, to be closely related to the phenomena of hysteria. In short, it is a case of hysterical hemianopsia.

## I

This symptom was reported a few years ago with less caution; it was, in fact, considered rather common. Briquet<sup>2</sup> describes it as frequent, which should not surprise us too much. This opinion was also supported in the work of Zvyons and de Galezowski<sup>3</sup> and in the thesis of Bellouard.<sup>4</sup> But in his 1882 thesis, M. Féré<sup>5</sup> discussed the observations that had been presented as cases of hysterical hemianopsia and showed that it always concerned either a true hemianopsia related to an encephalic lesion, or a simple concentric narrowing of the visual field, which is common among hysterics. In short, neither the existence of a true hemianopsia nor its dependence on hysteria could be admitted. Most authors who had seemed to admit the existence of hysterical hemianopsia eventually adopted this opinion, as can be seen from Rosenthal's letter to Charcot, published in M. Féré's thesis.

Later, a new notion was introduced into this study through the examination of certain cases of *ophthalmic migraine* which seemed to be of hysterical nature.

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<sup>1</sup> Janet, Pierre. "Un cas d'hémianopsie hystérique," Conférence faite à la salpêtrière le 25 janvier 1895, *Archives de Neurologie*, xxix (May, 1895), pp. 337-358.

<sup>2</sup> Briquet. — *Traité de l'hystérie*, p. 295.

<sup>3</sup> Zvyons. — *Amblyopie et amauroses hystériques*, 1873.

<sup>4</sup> Bellouard. — *De l'hémianopsie*. Paris, 1880.

<sup>5</sup> Féré. — *Cont. à l'étude des troubles fonctionnels de la vision par lésions cérébrales*, 1882.

Charcot, in his lecture of Tuesday, January 10, 1888,<sup>6</sup> Babinski,<sup>7</sup> Fink,<sup>8</sup> reported migraine phenomena with scintillating scotoma on one side and even transient hemianopia, which, according to later discussion, appeared to be rightly attributed to hysteria. But these hemianopic phenomena are always very fleeting, and it has been very difficult, if not impossible, to assess them precisely in an objective manner through examination of each eye with the perimeter. An examination of this kind conducted by M. Parinaud on a case of M. Babinski—although it was indeed a case of ophthalmic migraine triggered by suggestion—showed only a concentric narrowing of the visual field more marked than usual.

Thus all the authors who have spoken of this phenomenon—such as M. Greco (from Pisa), in *L'Hémianopsie hystérique*, 1891, and M. Gilles de la Tourette in his *Traité de l'hystérie*, from which we have borrowed some of the previous information—admit that hemianopsia, if it exists in hysterics as a result of an attack of ophthalmic migraine, is always transient and then appears as an exaggeration of the temporary concentric narrowing of the visual field.

In recent years, M. Pitres<sup>9</sup> has identified the central scotoma and hemianopsia as possibly occurring in hysteria, without strongly insisting on his own observations, but he states that these phenomena are very rare. In my own work on anesthesia, I recalled that in a large number of visual field examinations I had never observed in hysterical patients anything that resembled hemianopic phenomena, and I showed myself inclined to consider this symptom as doubtful in hysteria.<sup>10</sup> Around the same time, Mr. S. Freud wrote: "Hemianopsia has not yet been seen in hysteria, and I think it never will be."<sup>11</sup>

There is only one recent work to mention that precisely confirms hemianopsia, if not exactly in hysteria, then at least in a neurosis that can be considered somewhat related: neurasthenia. I am referring to the work of MM. Déjerine and Vialet "On a special form of functional hemianopsia in neurasthenia and traumatic neurosis."<sup>12</sup> The authors, in the cases they describe, do not admit any functional alteration of the nervous centers or the optic pathways, but regard the phenomenon as an ocular symptom of the same order as the narrowing of the visual field, with the same diagnostic and prognostic value. The opinion I wish to support concerning the case I am about to present to you is close to that one. It is therefore in opposition to most of the opinions expressed so far on this point, and to be justified, it requires a careful study of this peculiar pathological case.

## II

The patient we are going to study is a forty-two-year-old woman whom I have known and studied for a very long time. In fact—and this is not unimportant for

<sup>6</sup> Charcot. — *Leçons du mardi*, I, 88.

<sup>7</sup> Babinski. — *De la migraine ophthalmique hystérique*. (*Archives de Neurologie*, 1890, II, 305.)

<sup>8</sup> Fink. — *Des rapports de la migraine ophthalmique avec l'hystérie*, thèse 1891.

<sup>9</sup> Pitres. — *Leçons sur l'hystérie*, 1891, t. I, p. 98.

<sup>10</sup> Pierre Janet. — *Stigmata mentaux des hystériques*, 1893, p. 73.

<sup>11</sup> Sigm. Freud. — *Paralysies motrices organiques et hystériques*. (*Archives de Neurologie*, 1893, II, 36.)

<sup>12</sup> Déjerine et Vialet. — *Société de Biologie*, 28 juillet 1894.

the study of the facts I am about to present—it has been nearly five years since I first encountered this person in the service of my eminent master M. Falret, and I have continued to follow her regularly, without interruption, through all the incidents of her illness. I have already described this patient under the name “Justine,” and I have presented most of the incidents she previously exhibited in a fairly complete manner in an article published last spring by the *Revue philosophique*.<sup>13</sup>

Above all, she is a patient with fixed ideas; this is not a diagnosis, if you will, but at least the expression of the pathological symptom that has always been the most important in her case. For twenty consecutive years, she was tormented by a fixed idea that was both obsessive and impulsive: the idea of cholera, and this idea had brought her to a state of delirium in which she was admitted to the service of M. Falret. When this idea of cholera was erased from her mind by psychological procedures on which I have long insisted, I saw countless new fixed ideas emerge in her mind, related to the preceding one or derived by association without any real connection to it. It truly seemed that this mind, weakened by the original fixed idea, was no longer capable of resisting even the slightest influences, which continually provoked the appearance of secondary fixed ideas.

All these fixed ideas, the primary one as well as the secondary ones, had a particular character; they presented themselves in a special manner that I have been trying to highlight for some time in several works. They seem to me to be able to be designated under the name of *fixed ideas of hysterical form*. Fixed ideas constitute a veritable chaos in mental pathology, and most of the classifications made of them are far from definitive. It does not seem sufficient to me to distinguish them into obsessions, impulses, and phobias; these are valid distinctions, but somewhat superficial, as they are based more on the psychological content of the morbid idea than on its constitution and its laws. The same idea in the same patient can pass through these three forms; it is certainly useful to distinguish them. But to study the formation, to determine the prognosis and treatment of fixed ideas, it will be necessary, I believe, to define more precisely. Without seeking for the moment to classify all fixed ideas, I aim to set apart a fairly distinct group.

Some of these fixed ideas not only occur in hysterical patients, but also themselves possess, in their very nature, the characteristics of hysterical phenomena. These ideas are little known or not known at all by the patient himself, who perceives only their consequences or external manifestations. They manifest fully during hysterical attacks, in somnambulism, or even during certain states in which the patient’s normal consciousness is interrupted and which leave no clear memories; or they manifest in the form of subconscious phenomena that develop alongside normal consciousness, but without the patient’s awareness. These psychological characteristics, with such significant consequences, are what led me to designate this group of phenomena under the name “*fixed ideas of hysterical form*.”

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<sup>13</sup> Pierre Janet. — *Histoire d’une idée fixe*. (*Revue philosophique*, février 1894, p. 121.)

The fixed ideas of the patient I am describing to you presented themselves in this way in the form of extremely curious attacks—somnambulism, permanent contractures, subconscious writings, etc. Following a fairly prolonged moral treatment, this predisposition to subconscious phenomena and fixed ideas diminished, and for the past two years, it can be said that this person has not exhibited any appreciable symptom.

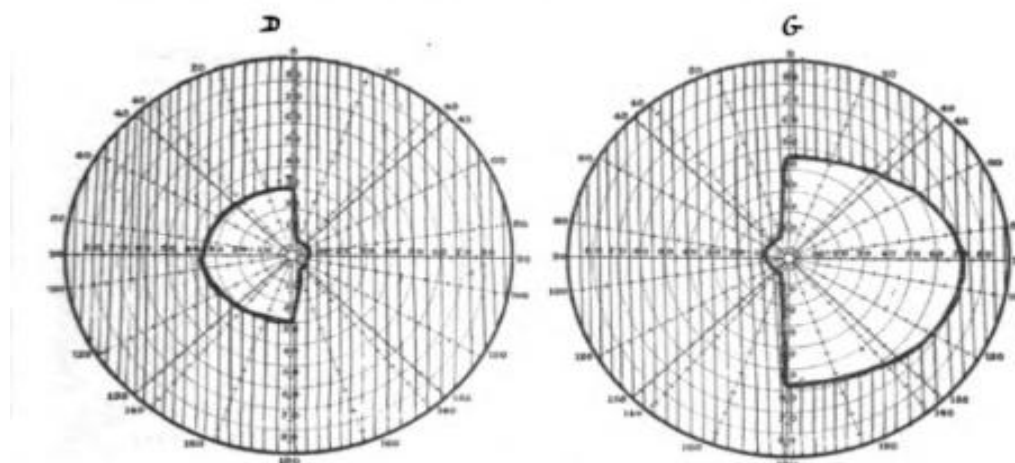
It was useful to remind you of these facts to help you better understand the present phenomena. For several months, approximately since June 1894, this woman has exhibited major irregularities in menstruation, particularly considerable uterine hemorrhages at the time of her periods. Concerned by these hemorrhages, I even sent the patient to M. Potherat, who kindly agreed to examine her condition. He observed no serious lesions, and although this person is only forty-two years old, he attributes these irregularities and hemorrhages to the onset of menopause.

Be that as it may, these hemorrhages led to a considerable weakening, following which nervous and mental disturbances that had disappeared for a long time reappeared in a more or less unusual form. The patient began complaining to me at the end of December about visual disturbances which we still observe today. First, she described a rather interesting but one we cannot fully interpret yet—*the persistence of visual images*. When she looks at object A and then shifts to another object B, the image of the first (A) persists and obstructs the view of the second (B); one must wait for some time before the image of B gradually appears through that of A. Justine had experienced similar phenomena, but in her case it was a certain determined image, a specific object—always the same one—that thus persisted in her vision, and the phenomenon was then connected with fixed ideas. Today, the same fact occurs more or less constantly for all objects that are attentively observed. This persistence of visual images seems to relate to other phenomena, such as the repetition of movements, repetition of words, etc., which are quite characteristic in her.

But we must now focus more exclusively on the second symptom. When Justine looked attentively at an object, she noticed that on one side—the side to her right—it was poorly seen, that it gradually disappeared. After a few days this symptom worsened, and at the beginning of January she came to complain *on her own*—note this fact—that she could no longer see *the left side* (always relative to herself) of all objects. The hemianopsia, which at first only existed during moments of fatigue, had become permanent: the patient was forced to move her eyes and look sideways in order to see entire objects; in normal fixation, she could see only the left side.

Even today, Justine fully describes the symptoms of a right hemianopsia. To verify them, the eyes must be examined with the perimeter and it must be determined as precisely as possible what her visual field is. The examination is easy for the left eye; it yields very clear results. The visual field is reduced in all directions: it is only 70° on the outer side, but it is enormously reduced on the inner side, where it is less than 10° (*fig. 1*). This is not, strictly speaking, a complete hemianopsia, since the boundary of the visual field does not pass through the fixation point but is located 5° to 8° beyond it. This is a well-known

feature of hemianopsias of central origin, in which a small portion of the visual field surrounding the fixation point is always preserved. Despite this detail, in this case there is an almost complete loss of half of the visual field.



*Fig. 1.*

The examination of the right eye is more difficult for reasons we will study shortly, but we can nonetheless measure the visual field. A much greater narrowing is observed than on the left side, since the most distant boundary is at  $35^\circ$  instead of  $70^\circ$ . But we also observe that one half of the visual field is suppressed in an even more complete way, since on that side vision does not extend more than  $5^\circ$  from the center. At the same time, we note a strange fact that greatly surprised me: for the right eye, the suppressed part is on the left; the hemianopsia is therefore internal—it is nasal. The fact is unusual, but it must be noted as it is. We are thus dealing with a person who complains of seeing objects only on the left side and who, under perimetric examination, presents a concentric narrowing of both visual fields, more pronounced for the right eye, with internal or nasal hemianopsia.

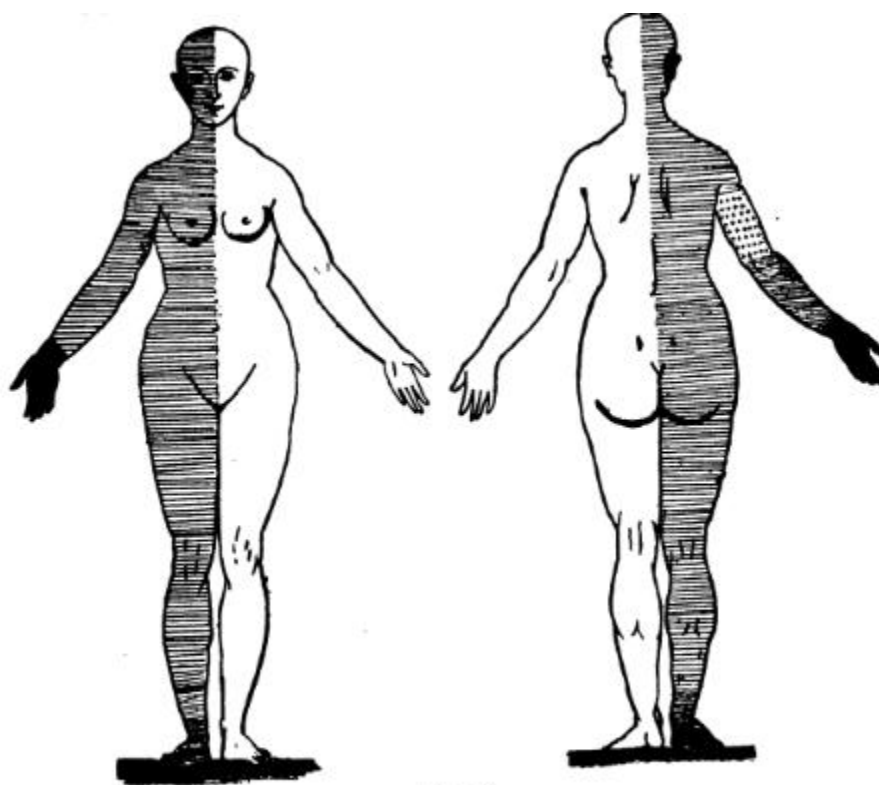
### III

That this hemianopsia exists and that it is permanent is unquestionable, but can we link this phenomenon to hysteria? Can we say that it is a case of hysterical hemianopsia? This question is very delicate, and without pronouncing categorically, I will point out to you some observations that may, in my opinion, support this view—reserving for the last one the fact that seems to me the most important.

(1) I must first recall—and insist on it all the more—that the patient is indeed truly a hysteric and that she currently presents all the stigmata of the neurosis. This fact is far from insignificant, but it is not demonstrative; for, in reality, a hysterical patient can have a hemianopsia due to any kind of cause unrelated to hysteria. We may suppose here that this woman, in addition to her hysteria which produces the concentric narrowing of the visual field, has in her brain some kind

of lesion that exerts a double compression on each side of the chiasm in such a way as to suppress vision in the outer lateral parts of each retina and thus produce the nasal hemianopsia that we observe;<sup>14</sup> this is theoretically possible. Let us not dwell on the symptoms of hysteria: the considerable and interesting aboulia, the enormous suggestibility, the amnesic phenomena, the somnambulisms, etc.

Let us note only the sensory stigmata, which are of interest. Justine was for a long time, at the height of her illness, in a state of total anesthesia. It is worth noting that this anesthesia was indeed more pronounced at the time when the fixed ideas were more numerous and more powerful. Then she was for a long time hemianesthetic on the right side. Today, she is not completely anesthetic but very strongly hypoesthetic over the entire right side of the body. Certain regions, such as the right hand up to the wrist, are completely anesthetic; others, such as the posterior region of the right arm where contractures once occurred, are rather hyperesthetic. You will also notice a very interesting patch of anesthesia that covers the entire outer ear and the region of the face and head immediately surrounding it (*fig. 2*).



*Fig. 2.*

■ Anesthésie complète. — ▨ Très forte hypoesthésie.  
 ★★★ Plaques d'hyperesthésie.

This anesthesia of the external organ is connected, according to a well-known law, to an anesthesia of the internal organ. Hearing is almost abolished on the right side. The patient hears only very loud sounds, and the ticking of a watch is

<sup>14</sup> Charcot. — *Mal. du syst. nerv.*, IV, 124.

perceived only very close to the ear. A particular detail: the sounds thus perceived by the right ear seem to the patient to come from the left side—there is, if I may be allowed this barbarism, a true allochiria of the ear.

The other senses are also severely affected: the muscular sense is almost completely abolished on the right; the senses of taste and smell are completely suppressed on both sides.

As for the visual sense, which interests us particularly at present, it exhibits to a high degree the characteristics of hysteria. Colors are well distinguished by both eyes, but normal visual acuity in the left eye is extremely weak in the right, barely 1/10. It is true that the examination of this eye is complicated because it shows a spasm of accommodation, which we will discuss shortly.

The visual field of both eyes has always been extremely variable: in moments of mental well-being it would expand until it became nearly normal. I showed that in such moments, it was enough to draw the patient's attention more strongly to the central point to determine a significant narrowing of this seemingly normal visual field.<sup>15</sup> Moreover, the visual field was most often constricted, just as it is now.

I will not dwell on other visual disturbances, such as a form of asthenopia that prevented the patient from fixing her attention on an object for long.<sup>16</sup> The preceding remarks are sufficient to strongly suggest that this is indeed a case of hysterical illness. This observation is all the more interesting because, even if it alone does not prove the hysterical nature of the new symptom of hemianopsia, it should also lead us to consider it as being of hysterical nature.

(2) Let us examine the hemianopsia itself instead. You have no doubt already been struck by a curious fact: it is the at least apparent contradiction between the patient's account and the objective examination of the visual fields. The patient complains, upon entering, that she cannot see the left side of objects. You immediately thought of a right homonymous hemianopsia and expected to find the visual field diagram similarly narrowed on both right sides. Instead, the diagram shows us a nasal hemianopsia. I cannot prove this fact to you by an example, as cases of nasal hemianopsia are rare; but I do not believe that a nasal hemianopsia gives the patient, when both eyes are open, the sensation of a right-sided hemianopsia. The patient should rather, in my view, see the right side and the left side of objects, but be obstructed by a more or less dark band that hides their center. The statement of our patient is therefore at the very least peculiar.

Here, however, is how it is explained by someone who knows her history. Justine has long suffered from a very interesting visual disorder that I previously studied with her with the help of M. Parinaud. She completely lacks, especially during periods of fatigue, binocular vision. Although both eyes are open and each should be capable of seeing if examined in isolation, the images provided by both eyes are not combined—the patient actually has alternating monocular vision; she sees either with one eye or the other, and preferably she sees with the left eye. I cannot insist here on this binocular vision disorder, which would take us too far afield. M. Parinaud explained it well, as you know: monocular vision is animal

<sup>15</sup> *Op. cit.*, p. 146, and *Stigmates mentaux des hystériques*, p. 76.

<sup>16</sup> *Op. cit.*, p. 145.



vision, whereas binocular vision is properly human vision, and in degenerates the latter disappears, leaving only elementary, animal vision. I tried to show that this binocular vision requires a synthetic effort in the mind, a higher cerebral function, and that the absence of this synthesis characterizes all hysterical phenomena.<sup>17</sup> Whatever this is, it is the disturbance of binocular vision—symmetrical, hysterical—which gives the appearance of hemianopsia, because the patient, although having both eyes open, perceives only the sensations from the left eye and ignores those of the right. The phenomenon of hemianopsia is here accompanied by a hysterical phenomenon intimately linked to it.

(3) We can make a similar observation by examining the phenomena that preceded and, in a way, prepared the hemianopsia. For a long time the patient has complained of very diverse visual phenomena; she has had double vision and in many forms—sometimes with both eyes, sometimes with only one eye. Let us not speak of all the phenomena of diplopia, but examine only those related to our subject. Here is how Justine described her impressions to me a few months ago: “When I look fixedly at an object,” she said, “the left side appears clearly to me, but the right side is poorly seen because it doubles—one half of your face is simple, the other is double.” One can verify this with a simple test: in the middle of a straight line I place a small cross and, at each end, a letter A and B. If the patient looks fixedly at the central cross with one eye only, with the left eye she sees letter A on the left as simple and letter B on the right as double. On the perimeter, we can determine the part of the visual field where objects are doubled: it is the inner part for the left eye, the right part—this is a rather bizarre and still poorly described phenomenon, I believe, of *monocular hemi-diplopia*.

One day, I noted again in my records from last summer that things were different: one side of objects—always the right side—enlarges excessively, while the left side remains normal, and we then have *monocular hemi-macropsia*; or else the opposite occurs—one side becomes very small, which is *hemi-micropsia*. Not to mention more complex combinations, for Justine once had, again with her left eye, *combined hemi-macropsia and monocular hemi-diplopia*; the left eye alone was active, and the right side of objects appeared both double and large. These are indeed strange facts; as I am not currently seeking to explain them, I will limit myself to this demonstration. Macropsia, micropsia, and monocular diplopia are rightly considered as hysterical symptoms. When we see hemianopsia appear in succession and precisely replace these in the same right half of the visual field of the left eye, are we not inclined to believe that this hemianopsia is of the same nature and must also be a hysterical phenomenon?

(4) Can we go further in the demonstration? Yes, one could look in this case of hemianopsia for the two characteristics that I have previously described as essential in hysterical anesthetics. These anesthetics, let us say, are *mobile and contradictory*. First, the anesthetics disappear and reappear under various influences—attacks, somnambulisms, suggestions, etc. This first characteristic of mobility has not yet been verified in the present case: first, the patient no longer has attacks and I do not intend to try to bring them back. She does, it is true, have somnambulisms that are easy to provoke, but, due to an unfortunate circumstance,

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<sup>17</sup> Pierre Janet. — *Histoire d'une idée fixe*. (*Revue philosophique*, février 1894, p. 147.)

it is impossible to get her to open her eyes during somnambulism; to obtain this result would require an education that would not be without its drawbacks and the results from the experimental point of view would lack precision. It is true that the patient is highly suggestible and that this hemianopsia, if it is hysterical, must disappear through suggestion. That is entirely my opinion, and I will even say that I am nearly certain it would disappear quickly. It is a pity that I present her to you today without having made any suggestions in this direction, which would not have failed to alter the phenomena.<sup>18</sup>

As for the second point—the *contradictory* nature of this hemianopsia—it is, on the contrary, an essential fact whose importance seems to me here quite preponderant. You are already familiar with the old studies by Charcot and Régnard in 1878, by M. Parinaud in 1886, which showed very troubling facts concerning hysterical achromatopsia. The sensation that patients claimed not to perceive nevertheless manifested by unmistakable signs—for example, a red color not perceived by the subject still caused a green afterimage. In 1886 and 1887, I myself studied these facts and showed that one could give the subject suggestions targeting a specific sensation in an area declared insensitive, and yet the suggestion would still be carried out very consistently.<sup>19</sup> I later applied this method to the study of visual field narrowing and even presented some of these experiments. A hysterical woman whose visual field had shrunk to a point, to 5°, would immediately fall asleep as soon as my finger, used as a signal, passed the 75° mark on the perimeter.<sup>20</sup>

It is this last experiment that I intend to repeat in order to definitively determine the hysterical nature of our patient's hemianopsia. Taking advantage of her extreme suggestibility, I suggested two things to her during somnambulism:

- (1) she must raise her arm involuntarily when I pinch her hand;
- (2) she must also raise her arm when she sees a piece of paper on my forehead.

This is a cue-based suggestion which, as you know, will be carried out through the mechanism of the association of ideas: at the moment of the tactile sensation of the pinch, the visual sensation of the paper on my forehead will exist in some form in the mind of the patient.

Well then, I pinch the *right* hand, the anesthetic hand as you know, and the arm rises abruptly. Although the patient claims to have felt neither the sensation nor the movement—which is explained by her tactile and muscular anesthesia—we nevertheless believe that this subconscious act must have been triggered by a similarly subconscious sensation. The persistence of this sensation, despite the apparent anesthesia of the right hand, shows us that this is a disturbance of personal perception, an anesthesia of assimilation—in a word, a hysterical anesthesia.

Well then, things happen exactly the same way for the eyes. With both eyes open, the patient looks at me and states that she does not see the left side of my face (from her perspective), “the right side,” she says, “is invisible.” I slowly

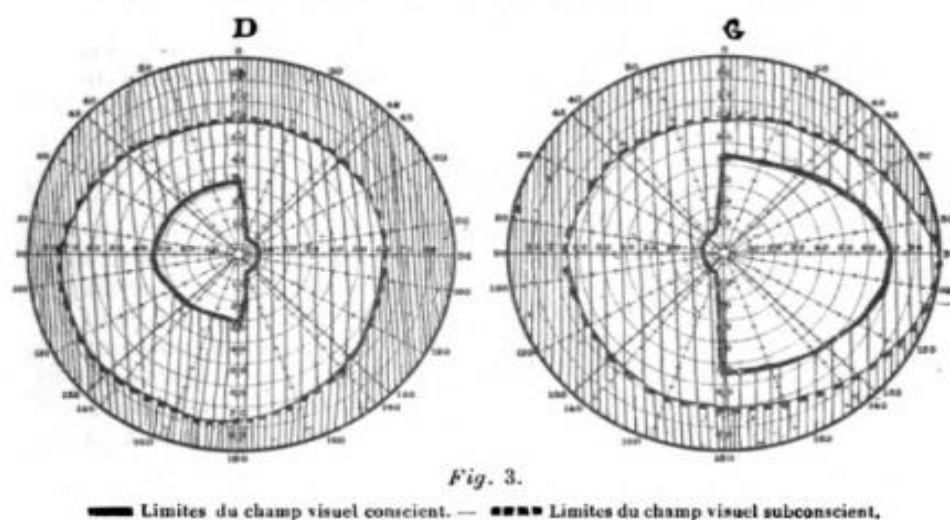
<sup>18</sup> See the note on the results of the treatment at the end of the article.

<sup>19</sup> *Anesthésie et dissociation*. (*Revue philosophique*, 1887, I, 467.)

<sup>20</sup> *Archives de Neurologie*, May 1892.

bring forward, or another person brings forward, a small piece of white paper on my forehead. The moment this paper touches the right side of my forehead, the patient's arm rises, even though she claims to have seen nothing. It is the same experiment and, in our opinion, the same conclusion.

This experiment can be performed with greater precision by using the perimeter. Thanks to appropriate suggestions that trigger subconscious movements when white papers or even colored ones are visible on the perimeter, one can determine in this woman the *subconscious* visual field, and it is interesting to compare it with the *conscious* visual field, which is, as you know, hemianopic (*fig. 3*).



This experiment is demonstrative; it shows us the persistence of subconscious sensations despite retinal anesthesia and demonstrates the hysterical nature of this hemianopsia.

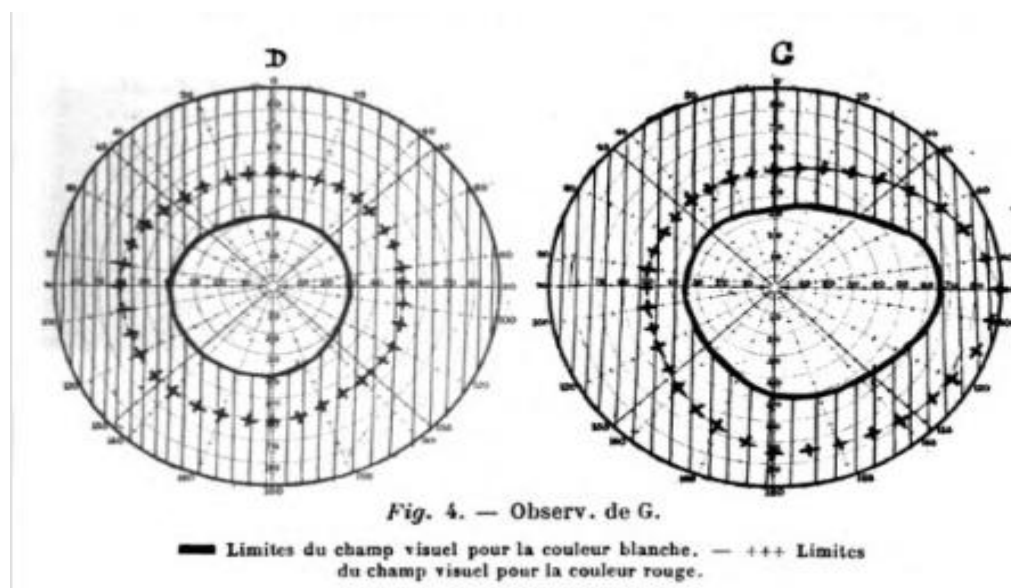
An important notion thus results from this long demonstration. Just as hemianopsia can appear in neurasthenia (Déjerine and Vialet), it can also appear in hysteria, and in this case, this symptom—as Déjerine and Vialet already stated—has no other diagnostic and prognostic significance than that of concentric narrowing of the visual field.

#### IV

Let us now try, while remaining within the domain of hysterical phenomena, to explain by what mechanism such a symptom could have been produced. If this were a true homonymous hemianopia, one would naturally be tempted to look for an anatomical explanation and to attribute the symptom to a particular exhaustion of one of the occipital lobes—a functional exhaustion that would not suppress elementary sensation as the destruction of that lobe would, but rather suppress consciousness, personal perception. This hypothesis and its discussion could be quite interesting. But I must admit that in this case, in the presence of a nasal hemianopsia of this nature, an anatomical localization of the specific disturbance

underlying its formation seems to me quite bold. I prefer to invoke a psychological mechanism and assign a role to those fixed ideas which, as I told you, constitute the fundamental characteristic of this patient's mind.

It is unquestionable that fixed ideas can play a role in the extent and fixation of the limits of the visual field. Not many cases have been described in which the shape of the visual field was determined by the fixed ideas of the patients, but perhaps this is because observers' attention has not been sufficiently drawn to this point. Allow me to recall a very striking case I noted in my records: a patient, G..., as a result of various incidents (she had conceived a horrible fear of the color red after seeing her brain surrounded by red flowers), developed an invincible horror of the color red. It is a frequently observed fact among hysterics that associations of extremely tenacious and powerful ideas exist, although they are not always consciously aware of them. If one forces G... to look at a red color for a long time, she has a hysterical attack in which she wants to tear out her brain, the red flowers, etc. With precautions, one can determine in her the conscious visual field for white and the limits of the same visual field for red. It is then observed that the visual field for red is strongly narrowed concentrically, while the visual field for white is much larger—almost normal on the left side (*fig. 4*). This persistence of the reduced visual field for red compared to that of white clearly shows that the particular attention the patient gives to that color—and the visual field is clearly modified by the fixed idea.



We can arrive at the same notion by means of suggestion experiments. I have not yet spoken to you about the effects of suggestion on the visual field, because these experiments would be of no use in establishing the delicate point in question—namely, to determine the hysterical nature of the phenomenon. That a phenomenon can be reproduced by suggestion in no way proves that it is always of hysterical nature: one can reproduce blisters by suggestion. The hysterical nature of a phenomenon must be demonstrated by the analysis of the phenomenon itself, independently of its experimental reproductions or imitations. But, the

hysterical nature of the phenomenon having been established, one may study the effects of suggestion to understand the mechanism of its production, to see whether ideas can play a role in its evolution. I believe this is exactly how Charcot proceeded in his famous analyses of cases of hysterical brachial monoplegia.

If we therefore study the effects of suggestion on the visual field, we arrive at a result that is easy to predict. You know that retinal sensitivity is not actually altered in hysteria and that, theoretically, hysterics can see just as we do across the full extent of the normal visual field. It is thus likely that, depending on the direction of their attention and the ideas that modify their conscious perceptions, their visual field can change in many ways. I have already shown, as have many other authors, that it can greatly expand and momentarily return to normal, that it can also shrink through suggestion, reduce to a point, and even disappear entirely in complete amaurosis. All this is unquestionable.

Can we now deform it in a more irregular way, suppressing only a part? I will remind you here only of a well-known experiment—systematized anesthetics. One can, by suggestion, make a certain person or even a considerable object disappear; is that not in reality suppressing a more or less significant part of the visual field—causing the subject not to see what is to the right or to the left? If such experiments are possible, then it must also be possible to suppress half of the visual field through direct suggestion.

This, moreover, is something that experimentation very easily confirms. I suggested to a hysterical patient that she had become half-blind in a peculiar way—that she could no longer see more than half of objects. The suggestion was carried out perfectly, at least insofar as it could be confirmed by her attitude and speech, for a subjective phenomenon like the perception of objects cannot be confirmed in any other way. But, one may say, this hemianopsia is not confirmed by objective methods, by *objective examination*—a term I have often seen used with regard to visual field testing. Let us be clear: visual field testing by means of the perimeter is not at all an *objective* examination, a physical test in which the subject's subjective feelings play no role, such as the examination of the eye's fundus. It is always a questioning of the subject—simply a somewhat more precise one. Well then, the suggested hemianopsia will be confirmed by perimeter testing, if the suggestion is given with enough precision. Twice I have observed suggested hemianopsias that I was perfectly able to chart on the perimeter and of which I provide an example here (*fig. 5*). This last observation answers the question we raised: yes, the visual field can be modified by the idea, and a hemianopsia can be produced by a fixed idea.

But is it really so? What is the peculiar fixed idea that this person may have had, more or less consciously, in relation to such a seemingly commonplace fact? It is very difficult to specify anything; I will refrain from making any assertions on this point and will limit myself to offering a few remarks.

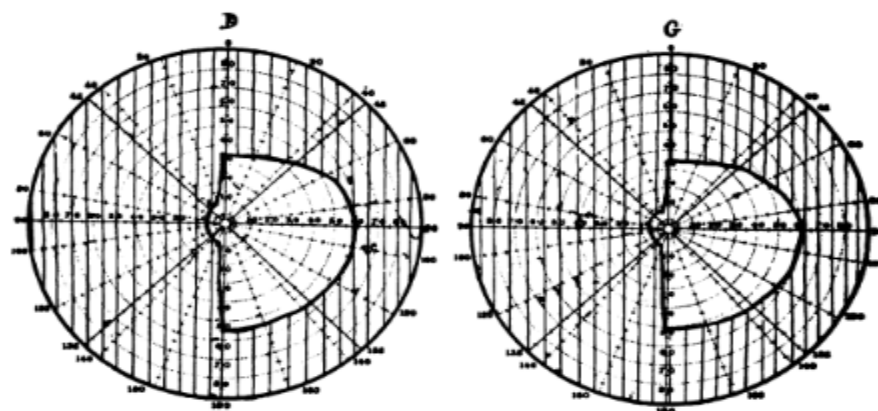


Fig. 5. — Hémianopsie droite homonyme déterminée par suggestion chez Br...

The main fact, let us not forget, is the right hemianopsia—the loss of vision on the right side—which manifests either in monocular vision through the left eye, the more functional eye, or even in binocular vision. Now, the right side is the one that has long been affected by the most pronounced symptoms. The right eye especially—about which we have not yet spoken—has exhibited and continues to exhibit a set of extremely curious functional disturbances.

This right eye previously exhibited—in a way covering the entire extent of the visual field—the disturbances we noted in the right half of the left eye's visual field. It showed macropsia, micropsia, monocular diplopia (whatever the mechanism, which we are not studying today). Today, this right eye shows fewer symptoms, yet in all its functions it presents more severe disturbances, still corresponding, however, with the hysterical state. The most notable is the constriction of the pupil—myosis. The right pupil is almost always smaller than the left. The pupillary reflexes of the right eye are altered, for the pupil does not dilate in darkness; it always remains in exaggerated contraction—this is a reflex disorder by spasm rather than by paralysis. This exaggeration of the pupillary reflex to light is all the more curious as it is accompanied by a decrease in retinal sensitivity and a considerable reduction in visual acuity. In any case, this pupillary irregularity, this myosis, this reflex disorder, and finally the hemianopsia that the patient complains of—this whole set of symptoms, if not carefully analyzed, would naturally suggest the gravest encephalic lesions. The case could be added to those so thoroughly studied in the thesis of M. Souques. In this instance, it would be a case of hysterical syndromes simulating encephalic conditions.

It is not, moreover, a case of simulation, as I have already had the opportunity to point out.<sup>21</sup> A careful examination, which M. Sauvinau kindly carried out on this patient, shows that there is no lesion of the fundus of the eye. All these symptoms, even the pupillary disturbances, are transitory. The myosis increases when the patient's relatives had already noticed for a long time that Justine was more tormented by her fixed ideas. I have often observed that following

<sup>21</sup> Pierre Janet. — *Revue philosophique*, February 1894, p. 148.

suggestions which erased the fixed ideas, or after somewhat prolonged sleep, this pupillary inequality completely disappeared. These are merely hysterical phenomena of the same nature as those we still have to point out in the right eye.

This eye exhibits, to the highest degree, the accommodation disorders that have been so well studied by M. Parinaud. This spasm of accommodation is difficult to observe and gives rise to many peculiar objections, often even contradictory ones. Indeed, it is enough to place a lens before the patient's eyes to produce an emotion, a suggestion if you will, which alters all the phenomena. It is likely that these right-eye disturbances originate from an actual inferiority of the right eye—a myopia which, I believe, existed prior to the nervous phenomena. You will not be surprised by these local inferiorities, these organic asymmetries, which M. Raymond often pointed out to us in patients classified as degenerates. All these disorders have made vision with the right eye difficult and, more or less, impossible.

Add to these remarks on the disorders presented by the right eye the fact that all other sensitivities on this side are likewise altered. I need only remind you of the tactile and muscular anesthesia, the absence of taste and smell, and finally the near-total deafness of the right ear. The patient, who has often been examined and who eventually noticed with sadness all these disorders affecting the right side, developed an entire theory about the misfortunes of that side: “It’s the cursed side,” she said. Through a naïve illusion, she attributes this kind of malediction to the objects themselves: “It’s annoying,” she says, “my piano is bad on the right side, while it’s good on the left.” Is it not possible that our patient took this idea even further, to the point of saying that the right side of objects was poorly seen, even invisible? Is that not what happened when the patient attributed to the right side of objects phenomena that in reality depended solely on the right eye—all those disorders, macropsia, micropsia, which initially were vague and merely disrupted normal vision? This idea, becoming fixed at the moment of the weakening caused by the hemorrhages of menopause, may have manifested as a right hemianopsia.

No doubt one may ask why all hysterical patients with right-sided hemianesthesia do not arrive, by the same reasoning, at right hemianopsia. Without dwelling too much on such a discussion, I will say that it is rare to see so many disturbances persist for so long in one eye on the same side, that these disturbances are not usually so noticeable, so thoroughly studied by the patient, and that there is not always at the same time such a strong predisposition to fixed ideas. In a word, a combination of circumstances, which are rarely united, prepared this patient for this rather unusual fixed idea and brought about the symptom she now presents.

There remains, you will say, the left hemianopsia for the right eye, which seems quite different. Let us first note that it manifests only slightly in normal binocular vision, since the patient does not use that eye. It appears only when the left eye is examined. It is, in my opinion, the logical consequence of the preceding idea. If the left eye does not see the left side of objects, the right eye must see only the right side of objects; each eye sees its own side. This is again a result of that

somewhat naive subconscious logic, which is one of the main characteristics of fixed ideas.

In general, taken as a whole, hysterical anesthesia is not the result of a fixed idea; it is the manifestation of a cerebral weakness, a diminution of personal perception, which is the primary fact. But the localizations of anesthesia, especially when they are precise and unusual, are indeed the result of suggestion and of the fixed idea. Since the examination of Justine's hemianopia began to be examined, it seems to me that it has become even more defined: vision has become clearer, broader on the left side, nearly absent on the right side, where it extends only slightly beyond the midline. We are dealing here, in summary, with a phenomenon that has so far been little observed—the determination of a shape of the visual field by the fixed idea.

If this very simple explanation of the facts has any merit, it is that it preserves the pathological unity of this patient, which is of interest. Justine continues to be a patient with fixed ideas, and these fixed ideas retain the hysterical form. All her incidents, over the years, have always been determined in the same way. I am not speaking only of her hysterical attacks and impulses, but even of her incidents with an organic appearance. She has had strangely localized pains, contractures of unusual form, and pareses. All of this was the result of subconscious fixed ideas of which the patient was rarely aware, and all the incidents disappeared when the fixed ideas were treated. It is likely that the same is still true, and the effects of treatment will confirm or disprove our supposition.<sup>22</sup>

In any case, the observation remains interesting in itself, as it shows us the existence of a disputed symptom of hysteria. More and more, hysteria is the great imitator, as Charcot so often said. It is increasingly difficult to assert that it is impossible to encounter a particular symptom in hysteria.

Dr. Pierre Janet

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<sup>22</sup> The treatment of this hemianopsia was begun immediately after the conference, and it fully confirmed our hypotheses. The visual field, even on the inner side, was mobile and could be displaced by various moral causes—attention, the association of ideas, suggestion. This mobility made it possible to obtain a cure within a few days. This recovery was accompanied by interesting phenomena. The patient complained of violent pains in the head at the moment when the visual field expanded. I have already emphasized the strange pains experienced by several patients at the moment their fixed ideas are overcome. At the moment the visual field increased in extent, it seemed to lose its acuity: the visual field was larger, but a part of its extent had become blurred. This is another example of those curious equivalences that appear when hysterical phenomena are displaced and which have already been described in transfers. Currently, the hemianopsia has disappeared; only the concentric narrowing of the visual field persists, for this latter symptom can only be suppressed temporarily.